

BEFORE THE  
BOARD OF REGISTERED NURSING  
DEPARTMENT OF CONSUMER AFFAIRS  
STATE OF CALIFORNIA

In the Matter of the Accusation Against:

**LUANNA JOUSHANPOOSH**  
**a.k.a. LUANNA CECILIA JOUSHANPOOSH**  
**a.k.a. LUAHNA CECILIA JOQSHANPOOSH**  
**a.k.a. LUANNA C. JOVSHANPOOSH**  
**6160 Pacheco Pass Hwy**  
**Hollister, CA 95023**

**Registered Nurse License No. 431723**

Respondent

Case No. 2012- 220

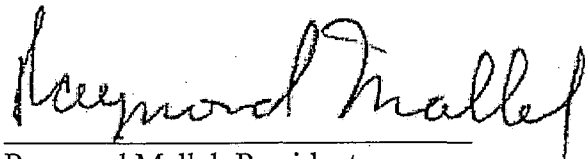
OAH No. 2011120920

**DECISION AND ORDER**

The attached Stipulated Settlement and Disciplinary Order is hereby adopted by the Board of Registered Nursing, Department of Consumer Affairs, as its Decision in this matter.

This Decision shall become effective on September 17, 2012..

IT IS SO ORDERED September 17, 2012.



Raymond Mallel, President  
Board of Registered Nursing  
Department of Consumer Affairs  
State of California

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Attorney General of California  
2 DIANN SOKOLOFF  
Supervising Deputy Attorney General  
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**BOARD OF REGISTERED NURSING**  
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13 **LUANNA CECILIA JOUSHANPOOSH,**  
14 **a.k.a. LUAHNA CECILIA**  
**JOQSHANPOOSH, a.k.a. LUANNA C.**  
15 **JOVSHANPOOSH**  
6160 Pacheco Pass Hwy  
16 Hollister, CA 95023  
Registered Nurse License No. 431723

17 Respondent.

Case No. 2012-220

OAH No. 2011120920

**STIPULATED SURRENDER OF  
LICENSE AND ORDER**

18  
19 IT IS HEREBY STIPULATED AND AGREED by and between the parties in this  
20 proceeding that the following matters are true:

21 PARTIES

22 1. Louise R. Bailey, M.Ed., RN (Complainant) brought this action solely in her official  
23 capacity as the Executive Officer of the Board of Registered Nursing and continues this action  
24 solely in her official capacity as the Interim Executive Officer of the Board of Registered  
25 Nursing. She is represented in this matter by Kamala D. Harris, Attorney General of the State of  
26 California, by Aspasia A. Papavassiliou, Deputy Attorney General.

2. Luanna Joushanpoosh (Respondent) is represented in this proceeding by attorney Guy J. Caputo, Esq., whose address is 1625 The Alameda, Suite 400, San Jose, CA 95126.

3. On or about August 31, 1988, the Board of Registered Nursing issued Registered Nurse License No. 431723 to Luanna Joushanpoosh (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought in Accusation No. 2012-220 but the license expired on October 31, 2011, and has not been renewed.

## JURISDICTION

4. Accusation No. 2012-220 was filed before the Board of Registered Nursing (Board), Department of Consumer Affairs, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on October 10, 2011. Respondent timely filed her Notice of Defense contesting the Accusation. A copy of Accusation No. 2012-220 is attached as Exhibit A and incorporated by reference.

## ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 2012-220. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and Order.

6. Respondent is fully aware of her legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to be represented by counsel, at her own expense; the right to confront and cross-examine the witnesses against her; the right to present evidence and to testify on her own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

7. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

1 CULPABILITY

2 8. Respondent understands that the charges and allegations in Accusation No. 2012-220,  
3 if proven at a hearing, constitute cause for imposing discipline upon her Registered Nurse  
4 License.

5 9. For the purpose of resolving the Accusation without the expense and uncertainty of  
6 further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual  
7 basis for the charges in the Accusation and that those charges constitute cause for discipline.  
8 Respondent hereby gives up her right to contest that cause for discipline exists based on those  
9 charges.

10 10. Respondent understands that by signing this stipulation she enables the Board to issue  
11 an order accepting the surrender of her Registered Nurse License without further process.

12 RESERVATION

13 11. The admissions made by Respondent in this stipulation are only for the purposes of  
14 this proceeding, or any other proceedings in which the Board of Registered Nursing or other  
15 professional licensing agency is involved, and shall not be admissible in any other criminal or  
16 civil proceeding.

17 CONTINGENCY

18 12. This stipulation shall be subject to approval by the Board of Registered Nursing.  
19 Respondent understands and agrees that counsel for Complainant and the staff of the Board of  
20 Registered Nursing may communicate directly with the Board regarding this stipulation and  
21 surrender, without notice to or participation by Respondent or her counsel. By signing the  
22 stipulation, Respondent understands and agrees that she may not withdraw her agreement or seek  
23 to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails  
24 to adopt this stipulation as its Decision and Order, the Stipulated Surrender and Disciplinary  
25 Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal  
26 action between the parties, and the Board shall not be disqualified from further action by having  
27 considered this matter.  
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13. The parties understand and agree that facsimile copies of this Stipulated Surrender of License and Order, including facsimile signatures thereto, shall have the same force and effect as the originals.

14. This Stipulated Surrender of License and Order is intended by the parties to be an integrated writing representing the complete, final, and exclusive embodiment of their agreement. It supersedes any and all prior or contemporaneous agreements, understandings, discussions, negotiations, and commitments (written or oral). This Stipulated Surrender of License and Order may not be altered, amended, modified, supplemented, or otherwise changed except by a writing executed by an authorized representative of each of the parties.

15. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Order:

## ORDER

IT IS ORDERED that Registered Nurse License No. 431723, issued to Respondent Luanna Joushanpoosh, is surrendered and accepted by the Board of Registered Nursing.

1. The surrender of Respondent's Registered Nurse License and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Board of Registered Nursing.

2. Respondent shall lose all rights and privileges as a registered nurse in California as of the effective date of the Board's Decision and Order.

3. Respondent shall cause to be delivered to the Board her pocket license and, if one was issued, her wall certificate on or before the effective date of the Decision and Order.

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 2012-220 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

**Exhibit A**

**Accusation No. 2012-220**

6. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Accusation No. 2012-220 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

## ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Order and have fully discussed it with my attorney, Guy J. Caputo, Esq. I understand the stipulation and the effect it will have on my Registered Nurse License. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Board of Registered Nursing.

6/2/2012

**LUANNA JOUSHANPOOSH**  
Respondent

I have read and fully discussed with Respondent Luanna Joushanpoosh the terms and conditions and other matters contained in this Stipulated Surrender of License and Order. I approve its form and content.

6/3/2012

**GUY J. CAPUTO, ESQ.**  
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted for consideration by the Board of Registered Nursing of the Department of Consumer Affairs.

Dated: June 4, 2012

Respectfully submitted,

KAMALA D. HARRIS  
Attorney General of California  
DIANN SOKOLOFF  
Supervising Deputy Attorney General



ASPASIA A. PAPAVALASSILIOU  
Deputy Attorney General  
*Attorneys for Complainant*

SF2011202003

1 KAMALA D. HARRIS  
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7 *Attorneys for Complainant*

8 **BEFORE THE**  
9 **BOARD OF REGISTERED NURSING**  
10 **DEPARTMENT OF CONSUMER AFFAIRS**  
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

Case No.

2012-220

13 LUANNA JOUSHANPOOSH, a.k.a.  
LUANNA CECILIA JOUSHANPOOSH,  
14 a.k.a. LUAHNA CECILIA  
JOQSHANPOOSH, a.k.a. LUANNA C.  
JOVSHANPOOSH  
6160 Pacheco Pass Hwy  
15 Hollister, CA 95023  
Registered Nurse License No. 431723

ACCUSATION

16 Respondent.

17  
18  
19 Complainant alleges:

20 PARTIES

21 1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her  
22 official capacity as the Executive Officer of the Board of Registered Nursing (Board),  
23 Department of Consumer Affairs.

24 2. On or about August 31, 1988, the Board issued Registered Nurse License Number  
25 431723 to Luanna Joushanpoosh, also known as Luanna Cecilia Joushanpoosh, also known as  
26 Luahna Cecilia Joqshanpoosh, also known as Luanna C. Jovshanpoosh (Respondent). The  
27 Registered Nurse License was in full force and effect at all times relevant to the charges brought  
28 in this Accusation and will expire on October 31, 2011, unless renewed.

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1           8.     Section 2762 of the Code states:

2            “In addition to other acts constituting unprofessional conduct within the meaning of this  
3 chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this  
4 chapter to do any of the following:

5            “(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed  
6 physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or  
7 administer to another, any controlled substance as defined in Division 10 (commencing with  
8 Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as  
9 defined in Section 4022.

10           ...

11           “(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any  
12 hospital, patient, or other record pertaining to the substances described in subdivision (a) of this  
13 section.”

14           9.     Code section 4060 provides:

15            “No person shall possess any controlled substance, except that furnished to a person upon  
16 the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor  
17 pursuant to Section 3640.7, or furnished pursuant to a drug order issued by a certified nurse-  
18 midwife pursuant to Section 2746.51, a nurse practitioner pursuant to Section 2836.1, [or] a  
19 physician assistant pursuant to Section 3502.1.”

20           10.    California Code of Regulations, title 16, section 1442, defines “gross negligence,” as  
21 used in Code section 2761, to include an extreme departure from the standard of care which,  
22 under similar circumstances, would have ordinarily been exercised by a competent registered  
23 nurse. Such an extreme departure means the repeated failure to provide nursing care as required  
24 or failure to provide care or to exercise ordinary precaution in a single situation which the nurse  
25 knew, or should have known, could have jeopardized the client’s health or life.

26           11.    California Code of Regulations, title 16, section 1443, defines “incompetence,” as  
27 used in Code section 2761, to mean the lack of possession of or the failure to exercise that degree  
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of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5.

12. California Code of Regulations, title 16, section 1443.5 states:

“A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

“(1) Formulates a nursing diagnosis through observation of the client’s physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

“(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client’s safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

“(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client’s health needs.

“(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

“(5) Evaluates the effectiveness of the care plan through observation of the client’s physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

“(6) Acts as the client’s advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided.”

1        13. Section 11173, of the Health and Safety Code states, in pertinent part:  
2        “(a) No person shall obtain or attempt to obtain controlled substances, or procure or attempt  
3 to procure the administration of or prescription for controlled substances; (1) by fraud; deceit,  
4 misrepresentation, or subterfuge; or (2) by concealment of a material fact.”

5                                CONTROLLED SUBSTANCES/DANGEROUS DRUGS

6        14. Code section 4021 states:  
7        “‘Controlled substance’ means any substance listed in Chapter 2 (commencing with Section  
8 11053) of Division 10 of the Health and Safety Code.”

9        15. Code section 4022 provides:  
10        “‘Dangerous drug’ or ‘dangerous device’ means any drug or device unsafe for self-use in  
11 humans or animals, and includes the following:

12        “(a) Any drug that bears the legend: ‘Caution: federal law prohibits dispensing without  
13 prescription,’ ‘Rx only’ or words of similar import.

14        “(b) Any device that bears the statement: ‘Caution: federal law restricts this device to sale  
15 by or on the order of a \_\_\_\_\_,’ ‘Rx only,’ or words of similar import . . .

16        “(c) Any other drug or device that by federal or state law can be lawfully dispensed only on  
17 prescription or furnished pursuant to Section 4006.”

18        16. Hydromorphone, also known as Dilaudid, is a Schedule II controlled substance as  
19 designated by Health and Safety Code section 11055, subdivision (d)(k), and a dangerous drug  
20 under Code section 4022. Hydromorphone is a hydrogenated ketone of morphine and is a  
21 narcotic analgesic. Its principal therapeutic use is relief of pain. Psychic dependence, physical  
22 dependence, and tolerance may develop upon repeated administration of narcotics; therefore,  
23 Hydromorphone should be prescribed and administered with caution.

24        17. Morphine Sulfate, also known by its brand name MS Contin, is a Schedule II  
25 controlled substance as designated by Health and Safety Code section 11055, subdivision  
26 (b)(1)(M), and a dangerous drug under Code section 4022. It is also a Schedule II controlled  
27 substance as designated by the Federal Code of Regulations, title 21, section 1308.12, subdivision  
28

1 (b)(1). Morphine, which is a central nervous system depressant, is a systemic narcotic and  
2 analgesic used in the management of pain.

3 18. Fentanyl is a Schedule II controlled substance as designated by Health and Safety  
4 Code section 11055, subdivision (c)(8), and a Schedule II controlled substance as designated by  
5 the Code of Federal Regulations, title 21, section 1308.12. It is also a dangerous drug under Code  
6 section 4022. Fentanyl's primary effects are anesthesia and sedation.

7 19. Lorazepam, also known by its trade name Ativan, is a Schedule IV controlled  
8 substance as designated by Health and Safety Code section 11057, subdivision (d)(16), and a  
9 Schedule IV controlled substance as designated by the Code of Federal Regulations, title 21,  
10 section 1308.14, subdivision (c). It is also a dangerous drug under Code section 4022. It is a  
11 psychotropic drug for the management of anxiety disorders or for the short-term relief of the  
12 symptoms of anxiety. Lorazepam can produce psychological and physical dependence and  
13 should be prescribed with caution.

#### 14 COST RECOVERY

15 20. Section 125.3 of the Code provides, in pertinent part, that the Board may request the  
16 administrative law judge to direct a licentiate found to have committed a violation or violations of  
17 the licensing act to pay a sum not to exceed the reasonable costs of the investigation and  
18 enforcement of the case.

#### 19 FACTUAL BACKGROUND

20 21. From on or about February 2008, to on or about September 2009, Respondent was  
21 employed as a registered nurse in the Intensive Care Unit at Santa Clara Valley Medical Center  
22 (SCVMC). Respondent resigned from SCVMC in or about September 2009 after she was  
23 counseled several times for her failure to follow policies and procedures for controlled  
24 substances, including Fentanyl and Morphine.

25 22. From on or about October 22, 2009, through on or about December 30, 2009,  
26 Respondent was employed by HRN Services, Inc. On or about December 30, 2009, Respondent  
27 was terminated from HRN Services, Inc., and was not eligible for re-employment. From on or  
28 about November 11, 2009, through on or about December 3, 2009, Respondent was assigned

1 through HRN to work in the Intensive Care Unit at Kaiser Permanente Hospital in San Jose,  
2 California. On or about November 17, 2009, Respondent was assigned to the care of Kaiser  
3 Patient 1 (KP 1). KP 1 had a physician's order dated November 24, 2009, for Hydromorphone 2  
4 milligrams every one hour as needed for pain. On or about November 17, 2009, at 4:11 p.m.,  
5 Respondent removed two vials of Hydromorphone 1 milliliter from the Pyxis for KP 1. The  
6 Pyxis is a computerized management, storage, and medication dispensing system utilized in  
7 hospital settings. The system can only be accessed with a password or bio-identification, or both.  
8 Respondent documented on the Medication Administration Record (MAR) that she administered  
9 Hydromorphone 1 milliliter to KP 1. Respondent and another nurse then returned the one  
10 remaining Hydromorphone 1 milliliter vial into the wrong Pyxis drawer. Respondent failed to  
11 administer the Hydromorphone 2 milligrams as ordered by KP 1's physician. Respondent also  
12 failed to document KP 1's pain level after she administered the Hydromorphone to KP 1.  
13 Respondent's HRN contract with Kaiser Permanente Hospital in San Jose was cancelled due to  
14 Respondent's failure to follow Kaiser's policies and procedures for controlled substances with  
15 respect to KP 1.

16 23. From on or about October 22, 2009, through on or about December 30, 2009,  
17 Respondent was assigned through HRN to work in the Intensive Care Unit at Saint Louise  
18 Regional Hospital (SLRH) in Gilroy, California. SLRH's Pharmacy's Pyxis anomalous usage  
19 report for December 2009 showed that Respondent had the highest number of controlled  
20 substance removals for December 2009. Furthermore, the Pyxis records indicated several  
21 instances where Respondent failed to document or account for controlled substances she removed  
22 from the Pyxis. On or about December 30, 2009, Respondent's contract with SLRH was  
23 cancelled due to Respondent's failure to follow hospital policies and procedures for controlled  
24 substances. Below are examples of Respondent's failure to follow SLRH's policies and  
25 procedures for controlled substances:

26 **PATIENT 1**

27 a. Patient 1 had a physician's order dated December 13, 2009, for Morphine 1  
28 milligram IV as needed for agitation. On or about December 11, 2009, at 4:09 p.m., Respondent

1 removed one vial of Morphine 2 milligrams from the Pyxis for Patient 1. At 4:10 p.m.,  
2 Respondent documented on the MAR and the Critical Care Flowsheet that she administered  
3 Morphine 1 milligram to Patient 1. Respondent failed to document administration or wastage, or  
4 otherwise account for the remaining 1 milligram of Morphine that she removed. Respondent did  
5 not complete any electronic notes.

6 b. On or about December 11, 2009, at 6:18 p.m., Respondent removed one vial of  
7 Morphine 2 milligrams from the Pyxis for Patient 1. At 6:15 p.m., three minutes prior to  
8 removing the medication from the Pyxis, Respondent documented on the MAR and the Critical  
9 Care Flowsheet that she administered Morphine 1 milligram to Patient 1. Respondent  
10 documented wastage of the remaining Morphine 1 milligram at 10:12 p.m., nearly four hours  
11 later. Respondent did not complete any electronic notes.

12 c. On or about December 13, 2009, at 7:47 p.m., Respondent removed one vial of  
13 Morphine 2 milligrams from the Pyxis for Patient 1. At 7:45 p.m., two minutes prior to removing  
14 the medication from the Pyxis, Respondent documented on the MAR and the Critical Care  
15 Flowsheet that she administered Morphine 1 milligram to Patient 1. Respondent failed to  
16 document administration or wastage, or otherwise account for the remaining 1 milligram of  
17 Morphine that she removed. Respondent did not complete any electronic notes.

18 d. On or about December 13, 2009, at 9:44 p.m., Respondent removed one vial of  
19 Morphine 2 milligrams from the Pyxis for Patient 1. At 9:45 p.m., Respondent documented on  
20 the MAR and the Critical Care Flowsheet that she administered Morphine 1 milligram to Patient  
21 1. Respondent documented wastage of the remaining Morphine 1 milligram at 10:12 p.m., nearly  
22 30 minutes after she removed it. Respondent failed to document Patient 1's pain scales and did  
23 not complete any electronic notes.

24 e. On or about December 14, 2009, at 12:05 a.m., Respondent removed one vial of  
25 Morphine 2 milligrams from the Pyxis for Patient 1. At 12:00 a.m., five minutes prior to  
26 removing the medication from the Pyxis, Respondent documented on the MAR that she  
27 administered Morphine 1 milligram to Patient 1. Respondent documented wastage of the  
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1 remaining Morphine 1 milligram at 1:38 a.m., nearly 1 hour and 30 minutes after she removed it.  
2 Respondent failed to document Patient 1's pain scales and did not complete any electronic notes.

3 f. On or about December 14, 2009, at 3:36 a.m., Respondent removed one vial of  
4 Morphine 2 milligrams from the Pyxis for Patient 1. At 3:30 a.m., six minutes prior to removing  
5 the medication from the Pyxis, Respondent documented on the MAR that she administered  
6 Morphine 1 milligram to Patient 1. Respondent wasted the remaining 1 milligram of Morphine.  
7 Respondent failed to document Patient 1's pain scales and did not complete any electronic notes.

8 g. On or about December 14, 2009, at 5:40 a.m., Respondent removed one vial of  
9 Morphine 2 milligrams from the Pyxis for Patient 1. At 5:40 a.m., Respondent documented on  
10 the MAR and that she administered Morphine 1 milligram to Patient 1. Respondent wasted the  
11 remaining 1 milligram of Morphine. Respondent failed to document Patient 1's pain scales and  
12 did not complete any electronic notes.

#### 13 PATIENT 2

14 h. On or about December 17, 2009, at 9:27 p.m., Respondent removed one vial of  
15 Lorazepam 2 milligrams from the Pyxis for Patient 2. At approximately 9:30 p.m., Respondent  
16 documented on the MAR and the Critical Care Flowsheet that she administered Lorazepam 1  
17 milligram to Patient 2. Respondent wasted the remaining Lorazepam 1 milligram with another  
18 nurse. Respondent failed to document Patient 2's pain scales and did not complete any electronic  
19 notes.

20 i. On or about December 25, 2009, at 10:13 p.m., Respondent removed one vial of  
21 Morphine 2 milligrams from the Pyxis for Patient 2. Patient 2 had a physician's order dated  
22 December 24, 2009 for Morphine Sulfate 1 milligram IV every one hour as needed for tube  
23 tolerance. At approximately 10:30 p.m., Respondent documented on the MAR and the Critical  
24 Care Flowsheet that she administered Morphine 1 milligram to Patient 2. Respondent wasted the  
25 remaining Morphine 1 milligram at 10:33 p.m., nearly 20 minutes after removing it. Respondent  
26 failed to document Patient 2's pain scales and did not complete any electronic notes.

27 j. On or about December 26, 2009, at 2:04 a.m., Respondent removed one vial of  
28 Morphine 2 milligrams from the Pyxis for Patient 2. At approximately 2:30 a.m., Respondent

1 documented on the MAR and the Critical Care Flowsheet that she administered Morphine 1  
2 milligram to Patient 2. Respondent failed to document administration or wastage of the  
3 remaining Morphine 1 milligram. Respondent also failed to document Patient 2's pain scales and  
4 did not complete any electronic notes.

5 k. On or about December 26, 2009, at 5:32 a.m., Respondent removed one vial of  
6 Morphine 2 milligrams from the Pyxis for Patient 2. At approximately 6:00 a.m., Respondent  
7 documented on the MAR and the Critical Care Flowsheet that she administered Morphine 1  
8 milligram to Patient 2. Respondent documented wasting the remaining Morphine 1 milligram at  
9 approximately 6:26 a.m., nearly one hour after removing it. Respondent failed to document  
10 Patient 2's pain scales and did not complete any electronic notes.

11 l. On or about December 26, 2009, at 9:40 p.m., Respondent removed one vial of  
12 Morphine 2 milligrams from the Pyxis for Patient 2. At approximately 10:00 p.m., Respondent  
13 documented on the MAR and the Critical Care Flowsheet that she administered Morphine 1  
14 milligram to Patient 2. Respondent failed to document administration or wastage of the  
15 remaining Morphine 1 milligram. Respondent also failed to document Patient 2's pain scales and  
16 did not complete any electronic notes.

17 m. On or about December 27, 2009, at 12:50 a.m., Respondent removed one vial of  
18 Morphine 2 milligrams from the Pyxis for Patient 2. At approximately 12:45 a.m., Respondent  
19 documented on the MAR and the critical care flowsheet that she administered Morphine 1  
20 milligram to Patient 2. Respondent documented wastage of the remaining Morphine 1 milligram  
21 at 12:55 a.m. Respondent failed to document Patient 2's pain scales and did not complete any  
22 electronic notes.

23 n. On or about December 27, 2009, at 2:57 a.m., Respondent removed one vial of  
24 Morphine 2 milligrams from the Pyxis for Patient 2. At approximately 3:00 a.m., Respondent  
25 documented on the MAR and the critical care flowsheet that she administered Morphine 1  
26 milligram to Patient 2. Respondent failed to document administration or wastage of the  
27 remaining Morphine 1 milligram. Respondent also failed to document Patient 2's pain scales and  
28 did not complete any electronic notes.

1 o. On or about December 27, 2009, at 4:54 a.m., Respondent removed one vial of  
2 Morphine 2 milligrams from the Pyxis for Patient 2. At approximately 5:00 a.m., Respondent  
3 documented on the MAR and the critical care flowsheet that she administered Morphine 1  
4 milligram to Patient 2. Respondent wasted the remaining Morphine 1 milligram with another  
5 nurse. Respondent failed to document Patient 2's pain scales and did not complete any electronic  
6 notes.

7 p. On or about December 27, 2009, at 6:19 a.m., Respondent removed one vial of  
8 Morphine 2 milligrams from the Pyxis for Patient 2. At approximately 6:20 a.m., Respondent  
9 documented on the MAR and the critical care flowsheet that she administered Morphine 1  
10 milligram to Patient 2. Respondent wasted the remaining Morphine 1 milligram with another  
11 nurse. Respondent failed to document Patient 2's pain scales and did not complete any electronic  
12 notes.

13 24. From on or about August 10, 2010, through on or about October 25, 2010,  
14 Respondent was employed as a registered nurse in the Intensive Care Unit at Hazel Hawkins  
15 Hospital in Hollister, California. Respondent was terminated while on probation due to  
16 unsatisfactory job performance. Specifically, Respondent had poor and inaccurate charting.

17 FIRST CAUSE FOR DISCIPLINE

18 (Unprofessional Conduct – Incompetence or Gross Negligence)  
19 (Bus. & Prof. Code § 2761, subd. (a)(1))

20 25. Complainant realleges the allegations set forth in paragraphs 21 through 24 and each  
21 of their subparts above, and incorporates them is fully set forth.

22 26. Respondent has subjected her registered nurse license to disciplinary action under  
23 Code section 2761, subdivision (a)(1), as defined by California Code of Regulations, title 16,  
24 sections 1442 and 1443, in that Respondent's conduct described in paragraphs 21 through 24 and  
25 each of their subparts above constitutes incompetence or gross negligence, or both, in carrying  
26 out usual certified or licensed nursing functions.  
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1 Board of Registered Nursing the reasonable costs of the investigation and enforcement of this  
2 case, pursuant to Business and Professions Code section 125.3;

3 3. Taking such other and further action as deemed necessary and proper.  
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6 DATED: October 10, 2011

for   
LOUISE R. BAILEY, M.ED., RN  
Executive Officer  
Board of Registered Nursing  
Department of Consumer Affairs  
State of California  
Complainant

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